

DEPARTMENT OF HEALTH AND FAMILY SERVICESDivision of Disability and Elder Services
DDE-2558 (Rev. 06/2005)**STATE OF WISCONSIN**Completion of this form meets the requirements of the State/County
contract specified under the Wisconsin Statutes.
S. 46.03 (12), 46.275, 46.278 (2)**COUNTY CRITICAL INCIDENT REPORT**

Instructions: This form must be completed in its entirety. Additional information may be attached to supplement information provided on the report form. FAX this form to the Bureau of Developmental Disabilities Services (BDDS) Critical Incident Contact in Central Office assigned to this individual within 30 days of the incident. Additional material that is not available due to reasons beyond the county's control may be sent under cover letter at a later date. Personally identifiable information on this form is collected for the purpose of improving quality of services and will only be used for that purpose.

1. Date Form Completed (mm/dd/yyyy)	2. Name - Primary Community Integration Specialist
3. Report Type (Check all appropriate) <input type="checkbox"/> Original <input type="checkbox"/> Update <input type="checkbox"/> Correction <input type="checkbox"/> Review Closed	4. Date Critical Incident Review Closed (mm/dd/yyyy)

PERSON COMPLETING FORM INFORMATION

5. Name - Last	Name - First
Title	
6. Name - Agency	7. Telephone Number

CASE MANAGER INFORMATION (If different from above)

8. Name - Last	Name - First
9. Telephone Number	10. Case Manager ID Number

PARTICIPANT INFORMATION

11. Name - Last	Name - First	MI
12. Birthdate (mm/dd/yyyy)	13. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	14. Medicaid Number
15. Telephone Number - Residential	16. Program <input type="checkbox"/> BIW <input type="checkbox"/> CIP 1A <input type="checkbox"/> CIP 1B <input type="checkbox"/> CSLA <input type="checkbox"/> Other	

EVENT

17. Date of Event (mm/dd/yyyy)	18. Location Event Occurred (Street, City, State, Zip Code)		
19. Type of Setting <table border="0"><tr><td><u>Residence</u> <input type="checkbox"/> Participant's private home or apartment <input type="checkbox"/> Adult family home (1-2 beds) <input type="checkbox"/> Adult family home (3-4 beds) <input type="checkbox"/> CBRF <input type="checkbox"/> Children's foster home</td><td><u>Other</u> <input type="checkbox"/> Work / day program <input type="checkbox"/> Community work site <input type="checkbox"/> Community setting; e.g., park, store, etc. <input type="checkbox"/> Transport <input type="checkbox"/> Another person's residence <input type="checkbox"/> Other - Specify: _____</td></tr></table>		<u>Residence</u> <input type="checkbox"/> Participant's private home or apartment <input type="checkbox"/> Adult family home (1-2 beds) <input type="checkbox"/> Adult family home (3-4 beds) <input type="checkbox"/> CBRF <input type="checkbox"/> Children's foster home	<u>Other</u> <input type="checkbox"/> Work / day program <input type="checkbox"/> Community work site <input type="checkbox"/> Community setting; e.g., park, store, etc. <input type="checkbox"/> Transport <input type="checkbox"/> Another person's residence <input type="checkbox"/> Other - Specify: _____
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20. Allegation of caregiver misconduct? <input type="checkbox"/> Yes <input type="checkbox"/> No			
21. Name - Provider Agency			
22. Address - Provider Agency (Street, City, State, Zip Code)			

INITIAL REPORT

23. Provide a brief description of initial event or allegation. Send additional documentation only if necessary.
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24. How did the reporter learn of this event?

If hospitalization or medical treatment was needed, complete the following.

25. Date of Treatment (mm/dd/yyyy) 26. Name - Institution Where Treatment Was Obtained

27. Reason for admission / treatment

28. Outcome of treatment

If the participant died, complete the following:

29. Date of Death (mm/dd/yyyy) 30. Official cause of death as reported on the death certificate

31. Check applicable event type(s) / allegations below. Check "Alleged Only" if there is doubt that the event occurred.

<u>Event Type / Allegation</u>	<u>Alleged Only</u>	<u>Event Type / Allegation</u>	<u>Alleged Only</u>
<u>Abuse</u>		<u>Neglect</u>	
<input type="checkbox"/> Mental / emotional	<input type="checkbox"/>	<input type="checkbox"/> Environmental	<input type="checkbox"/>
<input type="checkbox"/> Physical	<input type="checkbox"/>	<input type="checkbox"/> Fail to follow plan / poor care	<input type="checkbox"/>
<input type="checkbox"/> Sexual	<input type="checkbox"/>	<input type="checkbox"/> Medical / failure to seek	<input type="checkbox"/>
<input type="checkbox"/> Verbal	<input type="checkbox"/>	<input type="checkbox"/> Nutrition	<input type="checkbox"/>
		<input type="checkbox"/> Self-neglect	<input type="checkbox"/>
		<input type="checkbox"/> Unanticipated absence of provider	<input type="checkbox"/>
<u>Death</u>		<u>Residence Damage</u>	
<input type="checkbox"/> Accidental	<input type="checkbox"/>	<input type="checkbox"/> Fire	<input type="checkbox"/>
<input type="checkbox"/> Anticipated	<input type="checkbox"/>	<input type="checkbox"/> Other	<input type="checkbox"/>
<input type="checkbox"/> Related to psychotropic medication*	<input type="checkbox"/>	<input type="checkbox"/> Weather	<input type="checkbox"/>
<input type="checkbox"/> Related to restraint*	<input type="checkbox"/>		
<input type="checkbox"/> Related to suicide*	<input type="checkbox"/>		
<input type="checkbox"/> Unanticipated medical	<input type="checkbox"/>		
Note: *Deaths related to above factors in certain facilities must be reported to the Department / DSL Death Review Committee within 24 hours.		<u>Other</u>	
		<input type="checkbox"/> Serious illness / injury / accident	<input type="checkbox"/>
		<input type="checkbox"/> Significant behavior that placed others at risk	<input type="checkbox"/>
		<input type="checkbox"/> Suicide attempt	<input type="checkbox"/>
		<input type="checkbox"/> Other rights violations	<input type="checkbox"/>
		<input type="checkbox"/> Unanticipated absence of participant	<input type="checkbox"/>
<u>Hospitalization</u>			
<input type="checkbox"/> Emergency medical	<input type="checkbox"/>		
<input type="checkbox"/> Mental health / behavior	<input type="checkbox"/>		
<u>Law Authority Contact</u>			
<input type="checkbox"/> Commission of crime	<input type="checkbox"/>		
<input type="checkbox"/> Victim of crime	<input type="checkbox"/>		
<u>Misappropriation</u>			
<input type="checkbox"/> Person's funds	<input type="checkbox"/>		
<input type="checkbox"/> Person's property	<input type="checkbox"/>		

32. Contact checklist. Check all persons / agencies contact by county, provider and person / guardian. Fill in the first date contacted in regard to this event. *Contacts may be required depending upon circumstances.

<input type="checkbox"/>	A. Adult Protective Services	
	Name - Agency	Date - First Contact (mm/dd/yyyy)
	Name - Contact Person	Telephone Number - Agency
<input type="checkbox"/>	B. BDDS / Community Integration Specialist (CIS) (Required)	
	Name	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	C. Caregivers Investigation* (608) 261-7651	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	D. Child Abuse	
	Name - Agency	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	E. County Case Manager	
	Name -Contact Person	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	F. Elder Abuse	
	Name - Agency	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	G. Guardian (Required)	
	Name	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	H. Law Enforcement Agency	
	Name - Agency	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	I. Licensing *	
	<input type="checkbox"/> Adult Name - Agency	Date - First Contact (mm/dd/yyyy)
	<input type="checkbox"/> Children's Name - Agency	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	J. Other Providers If additional space is needed, attach separate sheet.	
	Name - Agency	Date - First Contact (mm/dd/yyyy)
	Name - Agency	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	K. Physician	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	L. Area Administration	
	Name	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	M. Residential Support Provider	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	N. Residential Support Provider	Date - First Contact (mm/dd/yyyy)
<input type="checkbox"/>	O. Wisconsin Coalition for Advocacy	Date - First Contact (mm/dd/yyyy)
	Telephone Number. - Madison (608) 243-2019	
	Telephone Number - Milwaukee (414) 342-8700	

33. Response Summary. Check all that apply; send updates as needed.

☐ **Nothing changed**

Case Management

☐ Additional services added to plan

☐ Higher level monitoring

☐ Terminated waiver participation

☐ Changed - New case manager is: _____

Day / Work Provider

☐ Same agency - staff changed

☐ Same agency - staff training provided

☐ Same agency - staff added

☐ Changed - New provider is: _____

Guardian

☐ Changed - New guardian is: _____

Telephone number: _____

Residential Provider

☐ Same agency - staff changed

☐ Same agency - staff training provided

☐ Same agency - staff added

☐ Changed - New provider is: _____

☐ **HFS 94 grievance filed**

☐ **Other** - Specify: _____

34. Narrative CI outcome.

35. In the internal reviews of this event, were there any recommendations offered to improve the quality of care for other waiver participants or changes in policy / procedure? If so, summarize what the recommendations / changes are and the plans for implementing them.

FOR BDDS USE ONLY

36. Name - Participant	37. Medicaid Number
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38. Name - Staff Member Who Completed This Form	39. Event Date	40. Review Date
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41. Check applicable event type(s) / allegations below. Check "Alleged Only" if there is doubt that the event occurred.

<u>Event Type / Allegation</u>	<u>Alleged Only</u>	<u>Event Type / Allegation</u>	<u>Alleged Only</u>
<u>Abuse</u>			
<input type="checkbox"/> Mental / emotional	<input type="checkbox"/>	<input type="checkbox"/> Environmental	<input type="checkbox"/>
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<u>Law Authority Contact</u>			
<input type="checkbox"/> Commission of crime	<input type="checkbox"/>		
<input type="checkbox"/> Victim of crime	<input type="checkbox"/>		
<u>Misappropriation</u>			
<input type="checkbox"/> Person's funds	<input type="checkbox"/>		
<input type="checkbox"/> Person's property	<input type="checkbox"/>		

42. BDDS Response Summary. Check all that apply and the date completed.

	<u>Date Completed</u>		<u>Date Completed</u>
<input type="checkbox"/> None		<input type="checkbox"/> Caregiver referral	
<input type="checkbox"/> Informal follow-up		<input type="checkbox"/> Formal POC issued	
<input type="checkbox"/> Behavior consult		<input type="checkbox"/> Formal POC issued	
<input type="checkbox"/> Provide training		<input type="checkbox"/> ISP revision	
<input type="checkbox"/> Additional field visit		<input type="checkbox"/> CI review closed	
<input type="checkbox"/> Licensing referral			

43. Provide any additional information about the event you need to add to the record.

44. Review Planning

	<u>Date Due</u>
<input type="checkbox"/> Plan of correction	
<input type="checkbox"/> Targeted review	

45. ☐ Yes ☐ No Are there attachments in the paper file?